STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154058	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCTORS NEUROPSYCHIATRIC HOSPITAL	417 S WHITLOCK ST BREMEN, IN 46506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS This visit was for one Federal hospital complaint investigation. Complaint Number: IN00177483 Substantiated: deficiency cited related to allegations. Date: 8/10/15 Facility Number: 012843 QA: cjl 08/14/15	A 000		
A 353	482.22(c) MEDICAL STAFF BYLAWS The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must: This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure medical staff enforced bylaws related to a complete medical record which accurately reflects the patient's condition and care for each individual evaluated or treated as an inpatient for 2 of 10 (patient P1 and P6) closed and open medical records reviewed, respectively. Findings: 1. Rules and Regulations of the Medical Staff, revised/reapproved 1/15, was reviewed on 8/11/15 at approximately 1540 hours and indicated, on pg 7, point 1., "The attending physician shall be held responsible for the preparation of a complete and legible medical	A 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/08/2015

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record for each individual evaluated or treated as an inpatient, patient which accurately reflects the patient's condition and care.

2. Policy #II-D.11, Photographing Wounds, was reviewed on 8/10/15 at approximately 1300 hours and indicated, "Wounds will be photographed within twenty-four hours of admission, at occurrence, weekly and at discharge if wound remains open. Photographs will be placed on the wound report...Include a disposable centimeter ruler in the photo for size reference. Document date and patient initials on disposable centimeter ruler being used...Place patient hospital identification label on photo edge, do not block wound or ruler in photo...complete all wound data."

3. Policy #II-D.10, Obtaining Wound Measurements, was reviewed on 8/10/15 at approximately 1305 hours and indicated, "Wounds will be measured wounds on admission, at occurrence, weekly and at discharge if wound remains open."

4. Policy #III-A.7, Content of the Medical Record, was reviewed on 8/10/15 at approximately 1310 hours and indicated, "Each medical record contains at least the following...Care provided to the patient before arrival, if any: If patients have been undergoing treatment in a hospital or other health care facility, a discharge form and a discharge summary along with other pertinent information should accompany the patient. This provided information to ensure ongoing continuity of care...Diagnostic and therapeutic orders, if any: On admission, diagnostic and therapeutic orders for the immediate care of the patient are included in the medical record. Also included are any

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orders given during episodes of care...Clinical observations...The clinical observations upon which care is based are a critical part of the medical record."

5. Review of closed and open patient medical records on 8/10/15 and 8/11/15 at approximately 1205 hours and 1015 hours, respectively, confirmed:

A. patient P1:

a. after being medically cleared in the Emergency Department (ED) for a left eye injury that was self-inflicted at F1, patient was transferred to F2 and admitted on an Emergency Detention Order for risk of self harm/harm to others.

b. History & Physical was done by D1 (Internal Medicine) on 7/6/15 at 1103 hours and assessment of patient's left eye confirmed, "a left eye ecchymosis noted from self injury while patient was at F1 which seems to be healing nicely,with no signs of acute infection. There is some mild scleral injection bilaterally."

c. Nurse's Notes confirm wounds documented as left eye, bilateral bruises on upper arms, bruise over pubic area, a stage II pressure ulcer to coccyx, and excoriation of testicles, scrotum, and bilateral thighs.

d. photograph of the left eye wound on 7/6/15 at 1605 hours:

i. lacked a disposable centimeter ruler in the photo for size reference.

ii. lacked a patient hospital identification label on photo edge.

iii. lacked measurement of wound.

iv. lacked complete wound documentation on wound report.

e. Admission Orders dated 7/5/15 at 1700 hours and Physician Orders from 7/5/15 at 1730

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through 7/7/15 at discharge lacked wound care orders.

f. Daily Nursing Assessment Flowsheets dated 7/6/15 day and night shifts lacked accurate documentation of patient's eye assessment.

B. patient P2 had a photograph of left forehead laceration wound with sutures on 8/8/15 at 1125 hours and it:

a. lacked date and patient initials on disposable centimeter ruler being used.

b. lacked a patient hospital identification label on photo edge.

c. lacked measurement of wound.

d. lacked complete wound documentation on wound report.

6. Staff P6 (Chief Executive Officer) was interviewed on 8/10/15 at approximately 1312 hours and 1740 hours and on 8/11/15 at approximately 1224 hours, and confirmed:

A. when photographing patient wounds, nursing staff should document all wound data and include a disposable centimeter ruler in the photo for size reference. The patient's initials along with the date should be written on the ruler and a patient identification label should be placed on the photo edge prior to taking the picture. Photographs of wounds should be done on admission, weekly and upon discharge if wound remains open as required by facility policy and procedure.

B. protocol is for nursing staff to do skin assessment on admission and if wounds present take photographs. Then they should contact a physician or nurse practitioner for wound care orders. Patient P1 had wounds documented and photographed the day after admission on 7/6/15 and lacked wound orders in the medical record.

C. protocol for getting pertinent patient

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A 353	Continued From page 4 information when receiving a patient from a nursing home (NH) is done by our intake coordinators. The information gathered should at least include H&P (history & physical), lab results, most recent nursing notes, current orders, current medications, current wound treatments, POA (power of attorney) documentation, and code status. Information from F2 to intake coordinator did not get relayed to staff at our facility on admission for patient P1. Therefore, patient continuity of care was lacking related to wound care orders and treatment. D. all patient information should be documented accurately on the Daily Nursing Assessment form. 7. Staff P1 (Licensed Practical Nurse [L.P.N.]) was interviewed on 8/10/15 at approximately 1500 hours, and confirmed: A. the box for PERRLA (pupils equal, round, reactive to light and accommodation) on Daily Nursing Assessment form on 7/6/15 day and night shift, and 7/7/15 day shift prior to discharge was not checked off on the eyes assessment for patient P1.	A 353		